Clinch County Hospital Authority
Hospital Transparency Requirements
Alternative 990 for Non-reporting Hospitals
6/30/2024

Organization Name	Clinch County Hospital Authority
Doing Business As	Clinch Memorial Hospital
Fiscal Year Start Date	7/1/2023
Fiscal Year End Date	6/30/2024
Employer Identification Number (EIN)	58-6011853
Primary Contact	Angela Handley, CEO

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Alternative 990 for Non-reporting Hospitals				
(A) For the calendar year, or tax year beginning 7/1/2023 and ending 6/30/2024				
(B) Check if applicable		(C) Name of organization	Clinch County Hospital Authority	(D) Employer Identification Number
Address Change		Doing business as	Clinch Memorial Hospital	58-6011853
Name Change		Number and street (or P.O. box if not delivered to street address	Room/suite	(E) Telephone Number
Initial Return		1050 Valdosta Hwy		912-487-5211
Final return/terminated		City or town, state or province, country, and ZIP or foreign postal code		H(a) Is this a group return for subordinates?
Amended return		Homerville, GA 31634		No
Application pending		(F) Name and address of principal filer	Angela Handley, CEO	H(b) Are all subordinates included?
		1050 Valdosta Hwy Homerville, GA 31634		

		Yes/No
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If “Yes,” complete Schedule C, Part I	No
4	Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If “Yes,” complete Schedule C, Part II	Yes
20a	Did the organization operate one or more hospital facilities? If “Yes,” complete Schedule H	Yes
20b	If “Yes” to line 20a, did the organization attach a copy of its audited financial statements to this return?	Yes
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? If “Yes,” complete Schedule I, Parts I and II	No
22	Did the organization report more than $5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? If “Yes,” complete Schedule I, Parts I and III	No
23	Did the organization answer “Yes” to Part VII, Section A, line 3, 4, or 5, about compensation of the organization’s current and former officers, directors, trustees, key employees, and highest compensated employees? If “Yes,” complete Schedule J	Yes
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? If “Yes,” complete Schedule R, Part I	No
34	Was the organization related to any tax-exempt or taxable entity? If “Yes,” complete Schedule R, Part II, III, or IV, and Part V, line 1	No
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	No
35b	If “Yes” to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? If “Yes,” complete Schedule R, Part V, line 2	No
36	Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? If “Yes,” complete Schedule R, Part V, line 2	No
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? If “Yes,” complete Schedule R, Part VI	No

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Part V	Statements Regarding Other IRS Filings and Tax Compliance			
				Yes/No
1a	Enter the number of reported in box 3 of Form 1096. Enter -0- if not applicable.	1a	8	
b	Enter the number of Forms W-2G included on line 1a. Enter -0- if not applicable.	1b	0	
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winning to prize winners?		1c	N/A
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	202	
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?		2b	Yes
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?		3a	No
b	If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in the space provided below.		3b	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?		4a	No
b	If "Yes," enter the name of the foreign country. See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).	4b		
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		5a	No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		5b	No
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?		5c	
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?		6a	No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		6b	
7	**Organizations that may receive deductible contributions under section 170(c)**			
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?		7a	No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?		7b	
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		7c	No
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d		
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		7e	No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		7f	No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		7g	
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		7h	
14a	Did the organization receive any payments for indoor tanning services during the tax year?		14a	No
b	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in the space provided below.		14b	
15	Is the organization subject to the section 4960 tax on payment(s) of more than $1,000,000 in remuneration or excess parachute payment(s) during the year?		15	No

Part V	Additional Comments

Part V Statements Regarding Other IRS Filings and Tax Compliance

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Part VI	**Governance, Management, and Disclosure.** For each "Yes" response to lines 2 through 7b below, and for a "No" response to line 8a, 8b, or 10b below, describe the circumstances, processes, or changes in the space provided below.			
	Section A. Governing Body and Management			**Yes/No**
1a	Enter the number of voting members of the governing body at the end of the tax year	1a	7	
b	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in the space provided below.	1b	7	
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?		2	No
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, trustees, or key employees to a management company or other person?		3	No
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?		4	No
5	Did the organization become aware during the year of a significant diversion of the organization's assets?		5	No
6	Did the organization have members or stockholders?		6	No
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?		7a	Yes
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?		7b	No
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
a	The governing body?		8a	Yes
b	Each committee with authority to act on behalf of the governing body?		8b	Yes
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in the space provided below.		9	No
	Section B. Policies (This Section B requests information about policies not required by the Internal Revenue Code.)			
10a	Did the organization have local chapters, branches, or affiliates?		10a	No
b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?		10b	
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?		11a	Yes
b	Describe on in the space provided below the process, if any, used by the organization to review this Form.			
12a	Did the organization have a written conflict of interest policy? If "No," go to line 13		12a	Yes
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?		12b	Yes
c	Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in the space provided below how this was done		12c	Yes
13	Did the organization have a written whistleblower policy?		13	Yes
14	Did the organization have a written document retention and destruction policy?		14	Yes
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?			
a	The organization's CEO, Executive Director, or top management official. If "Yes" explain in space provided below.		15a	Yes
b	Other officers or key employees of the organization. I. If "Yes" explain in space provided below.		15b	No
16a	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?		16a	No
b	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?		16b	
	Section C. Disclosure			
17	List the states with which a copy of this Form 990 is required to be filed	17	Georgia	
18	Section 6104 requires an organization to make its Forms 1023 (1024 or 1024-A, if applicable), 990, and 990-T (section 501(c) (3)s only) available for public inspection. Indicate how you made these available. Check all that apply.	18		
	Own Website			X
	Another's Website			
	Upon Request			X
	Other (explain in space provided below.)			

Part VI	**Governance, Management, and Disclosure.** For each "Yes" response to lines 2 through 7b below, and for a "No" response to line 8a, 8b, or 10b below, describe the circumstances, processes, or changes in the space provided below.			
19	Describe on in the space provided below whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.			
20	State the name, address, and telephone number of the person who possesses the organization's books and records.			
	Name		Madison Pope	
	Street Address - Line 1		1050 Valdosta Hwy	
	Street Address - Line 2			
	City		Homerville	
	State		Georgia	
	Zip Code		31634	
	Telephone Number		912-470-2347	

Part VI Additional Comments

Part VI, Line 7a-
Authority Board of Directors are appointed/nominated by the Board of Commissioners of Clinch County, Georgia (County).

Part VI, Line 12c-
Clinch Memorial Hospital enforces its Conflict-of-Interest Policy through a structured process that begins with employees, officers, directors, medical staff, and agents signing an acknowledgment that they have read and agree to follow the policy at hire and at designated intervals. When an actual or potential conflict arises, the individual involved must promptly disclose all relevant details to the Compliance Officer and the Board. The Compliance Officer reviews the disclosure, gathers necessary information, and forwards the matter to the Board or an authorized committee. During the meeting, the Interested Person may present facts but must leave the room before deliberation begins. The remaining disinterested members determine whether a conflict exists and, if so, direct the Interested Person to recuse themselves entirely from related discussions or votes. The Board may appoint a disinterested individual or committee to investigate alternatives and conduct due diligence to determine whether an alternative, conflict-free arrangement is available or whether the proposed transaction is fair, reasonable, and in the hospital's best interest. All discussions, decisions, disclosures, and votes are documented in the official minutes. If a failure to disclose is suspected, the Board notifies the individual, allows them to respond, investigates the matter, and, if a violation is confirmed, imposes appropriate corrective or disciplinary action. Ongoing monitoring, periodic reviews, audit oversight, and compliance training reinforce the hospital's commitment to transparency and ethical conduct.

Part VI, Line 15a-
The board of directors utilize GHA salary data guide in assessing and determining the CEO salary.

Part VI, Line 19-
The organization makes its governing documents, conflict of interest policy and financial statements available to the public when the request is made at the administrative office of the filing corporation.

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Part VII **Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors**

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

1a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See the instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (box 5 of Form W-2, box 6 of Form 1099-MISC, and/or box 1 of Form 1099-NEC) of more than $100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, and highest compensated employees who received more than $100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former** directors or trustees that received, in the capacity as a former director or trustee of the organization, more than $10,000 of reportable compensation from the organization and any related organizations.

See the instructions for the order in which to list the persons above.

Respond "No" if neither the organization nor any related organization compensated any current officer, director, or trustee.

	(A) Name and Title	(B) Average hours per week (list any hours related to organizations below dotted line)	(C) Positions (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC/1099-NEC)	(E) Reportable compensation from related organizations (W-2/1099-MISC/1099-NEC)	(F) Estimated amount of other compensation from the organization and related
			Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1)	Angela Handley										
	CEO	40.00			X				$ 158,949.00		$ 5,645.00
(2)	Madison O. Pope										$ -
	CFO	40.00			X				$ 129,909.00		$ 11,586.00
(3)	Igor Ancor										
	Physician/Medical Director	40.00					X		$ 314,078.00		
(4)	Healther E. Minshew										
	Nurse Practioner	40.00					X		$ 100,556.00		
(5)	Kate W. Rowe										
	I.C/Nurse Practtioner	40.00					X		$ 115,945.00		
(6)	Juanita R. Walker										
	Revenue Cycle Director	40.00					X		$ 120,845.00		
(7)	Stephen Bush										
	Secretary	1.00	X		X						
(8)	Louis Cassotta										
	Member	1.00	X								
(9)	Kay Hinson										
	Chairman	1.00	X		X						
(10)	Beth Jones										
	Member	1.00	X								
(11)	Courtney Tolle										
	Vice Chairman	1.00	X		X						
(12)	Kaye Riley										
	Member	1.00	X								
(13)											
(14)											
(15)											
(16)											
(17)											
(18)											
(19)											

Part VII	Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(20)											
(21)											
(22)											
(23)											
(24)											
(25)											
1b	Subtotal								$ 940,282.00	$ -	$ 17,231.00
c	Total from contribution sheets to Part VII, Section A										
d	Total (add lines 1b and 1c)								$ 940,282.00	$ -	$ 17,231.00

2	Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization		6
			Yes/No
3	Did the organization list any former officer, director, trustee, key employee, or highest compensated employee on line 1a? If “Yes,” complete Schedule J for such individual	3	No
4	For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than $150,000? If “Yes,” complete Schedule J for such individual	4	Yes
5	Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? If “Yes,” complete Schedule J for such pe	5	No

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Part VII	Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent		
	Section B. Independent Contractors		
1	Complete this table for your five highest compensated independent contractors that received more than $100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.		
	(A) Name and business address	**(B)** Description of services	**(C)** Compensation
	McKesson, 285 Evergreen Drive, Duluth, GA 30096	Purchase Drugs	$ 960,288.69
	Bencura, 125 Townpark Dr NW Ste 300, Kennesaw, GA 30144	PT Services	$ 674,814.64
	CCH Construction, Inc., 117 Commerce Park Drive, Thomasville, GA	Construction	$ 546,269.00
	Pharm D, 125 W Washington St Ste 780, Athens, GA 30601	Pharmacy	$ 493,592.64
	Southland Medical, 100 S Madison St, Thomasville, GA 31799	ER Doctors	$ 240,800.00
2	Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization		11

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Schedule C	**Political Campaign and Lobbying Activities** For Organizations Exempt From Income Tax Under Section 501(c) and Section 527		
	Complete if the organization is described below.		
	Name of organization Clinch County Hospital Authority	Employer identification number (EIN) 58-6011853	
Part I-A	**Complete if the organization is exempt under section 501(c) or is a section 527 organization.**		
1	Provide a description of the organization's direct and indirect political campaign activities in Part IV. See instructions for definition of "political campaign activities."		
2	Political campaign activity expenditures. See instructions		
3	Volunteer hours for political campaign activities. See instructions		
Part I-B	**Complete if the organization is exempt under section 501(c)(3).**		
1	Enter the amount of any excise tax incurred by the organization under section 4955		
2	Enter the amount of any excise tax incurred by organization managers under section 4955		
3	If the organization incurred a section 4955 tax, did it file Form 4720 for this year?		
4a	Was a correction made?		
b	If "Yes," describe in Part IV		
Part II-B	**Complete if the organization is exempt under section 501(c)(3) and has NOT filed Form 5768 (election under section 501(h)).**		
	For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	**Yes/No**	**Amount**
1	During the year, did the filing organization attempt to influence foreign, national, state, or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:		
a	Volunteers?		
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		
c	Media advertisements?		
d	Mailings to members, legislators, or the public?		
e	Publications, or published or broadcast statements?		
f	Grants to other organizations for lobbying purposes?		
g	Direct contact with legislators, their staffs, government officials, or a legislative body?		
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		
i	Other activities?	Yes	$ 2,655.66
j	Total. Add lines 1c through 1i		$ 2,655.66
2a	Did the activities in line 1 cause the organization to not be described in section 501(c)(3)?	No	
b	If "Yes," enter the amount of any tax incurred under section 4912		
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912		
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?		

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Schedule H	Hospitals			
	Name of organization		Employer identification number (EIN)	
	Clinch County Hospital Authority		58-6011853	
Part I	**Financial Assistance and Certain Other Community Benefits at Cost**			
1a	Did the organization have a financial assistance policy (FAP) during the tax year? If "No," skip to question 6a		1a	Yes
b	If "Yes," was it a written policy?		1b	Yes
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the FAP to its various hospital facilities during the tax year:			
	Applied uniformly to all hospital facilities			
	Applied uniformly to most hospital facilities			
	Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year			
a	Did the organization use federal poverty guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care:		3a	Yes
	100%			
	150%			
	200%	X		
	Other			
b	Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care:		3b	Yes
	200%			
	250%			
	300%	X		
	350%			
	400%			
	Other			
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.			
4	Did the organization's FAP that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?		4	Yes
5a	Did the organization budget amounts for free or discounted care provided under its FAP during the tax year?		5a	Yes
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?		5b	No
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		5c	
6a	Did the organization prepare a community benefit report during the tax year?		6a	Yes
b	If "Yes," did the organization make it available to the public?		6b	Yes

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

7	Financial Assistance and Certain Other Community Benefits at Cost	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
	Financial Assistance and Means-Tested Government Programs						
a	Financial assistance at cost (from Worksheet 1)			$ 56,239.00	$ -	$ 56,239.00	0.31%
b	Medicaid (from Worksheet 3, column a)			$ 1,414,400.00	$2,036,020.00	$ (621,620.00)	-3.39%
c	Costs of other means-tested government programs (from Worksheet 3, column b)			$ 60,236.00	$ 41,771.00	$ 18,465.00	0.10%
d	**Total.** Financial assistance and means-tested government programs	$ -	$ -	**$ 1,530,875.00**	**$2,077,791.00**	**$ (546,916.00)**	**-2.98%**
	Other Benefits						
e	Community health improvement services and community benefit operations (from Worksheet 4)			$ 206,326.00		$ 206,326.00	1.13%
f	Health professions education (from Worksheet 5)						
g	Subsidized health services (from Worksheet 6)			$ 1,245,492.00	$ 445,114.00	$ 800,378.00	4.37%
h	Research (from Worksheet 7)						
i	Cash and in-kind contributions for community benefit (from Worksheet 8)						
j	**Total.** Other benefits	$ -	$ -	**$ 1,451,818.00**	**$ 445,114.00**	**$1,006,704.00**	**5.50%**
k	**Total.** Add lines 7d and 7j	$ -	$ -	**$ 2,982,693.00**	**$2,522,905.00**	**$ 459,788.00**	**2.52%**

Part II **Community Building Activities.** Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

		(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1	Physical improvements and housing						
2	Economic development						
3	Community support						
4	Environmental improvements						
5	Leadership development and training for community members						
6	Coalition building						
7	Community health improvement advocacy						
8	Workforce development						
9	Other						
10	**Total**	$ -	$ -	$ -	$ -	$ -	0%

Part III **Bad Debt, Medicare, & Collection Practices**

Section A. Bad Debt Expense

1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?		1	Yes
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount	2	$1,860,380.00	
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's FAP. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit	3	0	
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	8,082,711.00	
6	Enter Medicare allowable costs of care relating to payments on line 5	6	8,176,258.00	
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	(93,547.00)	
8	Describe in Part VI the extent to which any shortfall reported on line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:			
	Cost accounting system			
	Cost to charge ratio			
	Other			

Section C. Collection Practices

9a	Did the organization have a written debt collection policy during the tax year?		9a	Yes
b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI		9b	Yes

Part IV **Management Companies and Joint Ventures** (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

	(a) Name of Entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers', directors', trustees', or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					

Schedule H Hospitals

Part V Facility Information

Section A. Hospital Facilities (list in order of size, from largest to smallest—see instructions)

How many hospital facilities did the organization operate during the tax year?

	Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility):	Licensed hospital	General medical & surgical	Children's hospital	Critical access hospital	Research facility	ER-24 hours	ER-Other	Other (describe)	Facility reporting group
1	Clinch Memorial Hospital 1050 Valdosta Highway Homerville, GA 31634 clinchmh.org 032-634	X	X		X		X		SWB	
2										
3										
4										
5										
6										
7										
8										
9										
10										

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility (list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year?

	Name and address	Type of facility (describe)
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Part VI Supplemental Information

Provide the following information in the space provided below

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8, and 9b

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's FAP.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (for example, open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

Part I , Line 7 - Costing Methodology Explanation
The costs for Part 1, lines 7a and 7b were calculated using the ratio of costs to charges using Worksheet 3 in the instructions form.

Part III, Line 2 – Bad Debt Expense Methodology
Amounts included on Part III line 2 represent the amount of charges considered uncollectible. Pursuant to ASU No. 2014-09 (Topic 606) discussed in more detail below, the amount identified as bad debt on Schedule H, Part II, Line 2 primarily represents amounts estimated at the transaction date that are considered a price concession.

Part III, Line 4 – Bad Debt Expense Footnote to Financial Statements –
The Hospital provides an allowance for doubtful accounts based on the evaluation of the overall collectability of the accounts receivable. As accounts are known to be uncollectible, the accounts are charged against the allowance.

Part III, Line 8 – Medicare Explanation
Medicare allowable costs are computed in accordance with cost reporting methodologies utilized on the Medicare Cost Report and in accordance with related regulations. Indirect costs are allocated to direct service areas using the most appropriate statistical basis.

Part III, Line 9b – Collection Practices Explanation
Patients will receive 4 statements and multiple phone calls requesting payment in full or payment arrangements be made. If there has been no response after three statements have been issued, then the patient slash guarantor will receive a balance due letter. If there is no response within 10 days, then the patient will receive a final demand letter. If there continues to be no response, then the accounts are sent to an outside collection agency on the 121st day, the application for financial assistance. , if 240 days from the date of the first post discharge bill an account may be turned over of outside collection efforts after the initial 120 day notification.
-Phone calls - 21 days after the initial statement. The patient may begin to receive multiple phone calls or pressing the payment in full or payment arrangements being made.
- News of outside collection agency - When a patient and or guarantor failed to feed the patient liability, the account when we referred to an outside collection agency in accordance with the schedule of the Business Office Manager will be responsible for

Schedule H **Hospitals**

ensuring that CMH has made reasonable efforts to determine whether a patient is eligible. Financial assistance for AS being sent to a collection agency.
- Extraordinary collection actions (ECA) - The patient and/ or guarantor Shall be provided with at least 30 days written notice prior to any EC's being taken. Their written notice will include a plain language summary of the financial assistance policy, notification of any EC's that may be initiated against the patient and or guarantor, and the date after which an EC's will be initiated. Oral notification to the patient and or guarantor will be attempted via phone call prior to any EC's being initiated. The oral notification will inform the patient and their guarantor but the financial assistance policy and how to obtain help with the financial assistance application process.
- Legal actions- Legal actions may be initiated against the patient and or guarantor who default on payment to clinch memorial these legal actions may include.
-Placing a lien on personal property.
-Reporting adverse information to credit bureaus; and
-Garnishing an individual's wages what Legal actions taken by any collection agency on behalf of Clinch Memorial shall have Had prior review and approval.
CMH or any collections agency working on behalf of CMH shall not pursue enforcement of a judgement lien, whether by Sheriff's levy or sale or otherwise, on primary residence, purse an involuntary bankruptcy proceeding against a patient and/ or Guarantor, or take any action that would cause a bench warrant (an order issued by a judge or court for the arrest of a person) to be issued. However, CMH may pursue appropriate court orders, including contempt of court, for a patient/judgement debtor failing to respond to post- judgement discovery as required by law. See Official Code of Georgia Annotated Sect, 9-11-69 and Official Code of Georgia Annotated Sect. 9-11-37.

Part VI, Line 2 – Needs Assessment
The organization facilitated a community survey with the help of the steering committee and recruited key stakeholders for focus group discussions. The community survey was disseminated via the hospital's social media webpages and email listserv, as well as those of local partners. The Community Health Needs Assessment can be found at https://clinchmh.org/community-health-needs-assessment/.

Part VI, Line 3 – Patient Education of Eligibility for Assistance
Patient financial assistance information is available online, by phone or by mail. Patient statements highlight the organization's charity program and encourage patients to call for financial assistance.The Plain Language Summary, Policy and application can be found at https://clinchmh.org/patient-services/.
Part VI, Line 4 – Community Information
Clinch Memorial Hospital serves Clinch County.
Part VI, Line 5 – Promotion of Community Health
The hospital's suggestions for promoting community health were partnering with the school system to promote healthy lifestyle choices, particularly amount students and improving communication with community members and advertising their services to strengthen the hospital's position within the community.
Part VI, Line 7 – State Filings of Community Benefit Report
Georgia

Clinch County Hospital Authority
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Schedule H Part V	**Hospitals**			
	Facility Information			
	Section B. Facility Policies and Practices (complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)			
	Name of hospital facility or letter of facility reporting group:			Clinch Memorial Hospital
	Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group **(from Part V, Section A)**			1
	Community Health Needs Assessment (CHNA)			**Yes/No**
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?		**1**	No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C		**2**	No
3	During the tax year or either of the 2 immediately preceding tax years, did the hospital facility conduct a CHNA? If "No," skip to line 12. If "Yes," indicate what the CHNA report describes (check all that apply):		**3**	Yes
a	A definition of the community served by the hospital facility	**3a**	X	
b	Demographics of the community	**3b**	X	
c	Existing health care facilities and resources within the community that are available to respond to the health needs of the community	**3c**	X	
d	How data was obtained	**3d**	X	
e	The significant health needs of the community	**3e**	X	
f	Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	**3f**	X	
g	The process for identifying and prioritizing community health needs and services to meet the community health needs	**3g**	X	
h	The process for consulting with persons representing the community's interests	**3h**	X	
i	The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA	**3i**	X	
j	Other (describe in Section C)	**3j**		
4	Indicate the tax year the hospital facility last conducted a CHNA:		**4**	2022
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted		**5**	Yes
6a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C		**6a**	No
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C		**6b**	No
7	Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply):		**7**	Yes
a	Hospital facility's website (list url)	**7a**	X	https://clinchmh.org
b	Other website (list url):	**7b**		
c	Made a paper copy available for public inspection without charge at the hospital facility	**7c**	X	
d	Other (describe in Section C)	**7d**		

Schedule H Part V	Hospitals			
	Facility Information			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11		8	Yes
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 2022		9	2022
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?		10	Yes
a	If "Yes," list url:	10a	X	https://clinchmh.org
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?		10b	
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		12a	No
b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		12b	
c	If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities?			
	Financial Assistance Policy (FAP)			
	Name of hospital facility or letter of facility reporting group:		Clinch Memorial Hospital	
	Did the hospital facility have in place during the tax year a written FAP that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? 13 If "Yes," indicate the eligibility criteria explained in the FAP:		13	Yes
a	FPG, with FPG family income limit for eligibility for free care of and FPG family income limit	13a	X	200%
	for eligibility for discounted care of			
b	Income level other than FPG (describe in Section C below)	13b		
c	Asset level	13c		
d	Medical indigency	13d	X	
e	Insurance status	13e		
f	Underinsurance status	13f		
g	Residency	13g		
h	Other (describe in Section C below)	13h		
14	Explained the basis for calculating amounts charged to patients?		14	Yes
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):		15	Yes
a	Described the information the hospital facility may require an individual to provide as part of their application	15a	X	
b	Described the supporting documentation the hospital facility may require an individual to submit as part of their application	15b	X	
c	Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process	15c	X	
d	Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications	15d		
e	Other (describe in Section C below)	15e		
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):		16	Yes
a	The FAP was widely available on a website (list url):	16a	X	https://clinchmh.org
b	The FAP application form was widely available on a website (list url):	16b	X	https://clinchmh.org

Schedule H Part V	Hospitals Facility Information			
c	A plain language summary of the FAP was widely available on a website (list url):	16c	X	https://clinchmh.org
d	The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)	16d	X	
e	The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)	16e	X	
f	A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)	16f	X	
g	Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention	16g	X	
h	Notified members of the community who are most likely to require financial assistance about availability of the FAP	16h	X	
i	The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by limited-English proficiency (LEP) populations	16i		
j	Other (describe in Section C below)	16j		
	Billing and Collections			
	Name of hospital facility or letter of facility reporting group:		Clinch Memorial Hospital	
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written FAP that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?		17	Yes
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		18	
a	Reporting to credit agency(ies)	18a		
b	Selling an individual's debt to another party	18b		
c	Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP	18c		
d	Actions that require a legal or judicial process	18d		
e	Other similar actions (describe in Section C)	18e		
f	None of these actions or other similar actions were permitted	18f	X	
19	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged:		19	No
a	Reporting to credit agency(ies)	19a		
b	Selling an individual's debt to another party	19b		
c	Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP	19c		
d	Actions that require a legal or judicial process	19d		
e	Other similar actions (describe in Section C)	19e		
20	Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) on line 19 (check all that apply):			
a	Provided a written notice about upcoming extraordinary collection actions (ECAs) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C)		20a	Yes
b	Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)		20b	Yes
c	Processed incomplete and complete FAP applications (if not, describe in Section C)		20c	Yes
d	Made presumptive eligibility determinations (if not, describe in Section C)		20d	Yes

Schedule H	Hospitals			
Part V	**Facility Information**			
e	Other (describe in Section C)		**20e**	
f	None of these efforts were made		**20f**	
	Policy Relating to Emergency Medical Care			
21	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's FAP? If "No," indicate why:		**21**	Yes
a	The hospital facility did not provide care for any emergency medical conditions	**21a**		
b	The hospital facility's policy was not in writing	**21b**		
c	The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)	**21c**		
d	Other (describe in Section C)	**21d**		
	Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)			
	Name of hospital facility or letter of facility reporting group:		Clinch Memorial Hospital	
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care:		**22**	Yes
a	The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period	**22a**		
b	The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period	**22b**	X	
c	The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period	**22c**		
d	The hospital facility used a prospective Medicare or Medicaid method	**22d**		
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C		**23**	No
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C		**24**	No

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24 in the space provided below. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

Part V, Line 5

The project team worked with the hospital CHNA steering committee throughout the project. The steering committee facilitated completion of a community survey, recruited key stakeholders for focus group discussions, and provided information about the hospital's activities to address community health needs since the last CHNA was completed in 2022.

The community survey that was administered aimed at assessing local health care access and needs of the people residing in the primary service area of Clinch Memorial Hospital – Clinch County. The community survey was disseminated via the hospital's social media webpages and email listservs, as well as those of local community partners. Focus group participants were all key stakeholders in maintaining the overall health of Clinch County. Their perspectives provided a well-rounded view of life in the community and the health and health care needs of the residents.

Part V, line 11-

Schedule H	Hospitals
Part V	Facility Information

The hospital identified significant needs of the following:
Substance Abuse
Mental Health
Chronic conditions
Lack of Exercise opportunities
Lack of Specialists
The hospital plans to address these needs by:
-Re-starting community farmers markets on a quarterly basis and develop relationships with satellite farmers
-develop a healthy eating campaign
-create opportunities for free, healthy, community exercise
- establish semi-annual training for teen girls and boys
-promote cancer screenings
-increase existing mental services

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Schedule I	**Grants and Other Assistance to Organizations, Governments, and Individuals In the United States**	
	Name of organization	Employer identification number (EIN)
	Clinch County Hospital Authority	58-6011853

Part I	**General Information on Grants and Assistance**	
		Yes/No
1	Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance?	
2	Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.	

Part IV	**Supplemental Information.** Provide the information required in Part I, line 2; Part III, column (b); and any other additional information in the space provided below.

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Schedule I **Grants and Other Assistance to Organizations, Governments, and Individuals In the United States**
Part II **Grants and Other Assistance to Domestic Organizations and Domestic Governments.** Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that received more than $5,000. Part II can be duplicated if additional space is needed.

1	(a) Name and address of organization or government	(b) EIN	(c) IRC Section if applicable (ex. 501c3)	(d) Amount of cash grant	(e) Amount of Noncash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
(1)								
(2)								
(3)								
(4)								
(5)								
(6)								
(7)								
(8)								
(9)								
(10)								
(11)								
(12)								

2	Enter total number of section 501(c)(3) and government organizations listed in the line 1 table	
3	Enter total number of other organizations listed in the line 1 table	

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Schedule I Part III	**Grants and Other Assistance to Organizations, Governments, and Individuals In the United States**					
	Grants and Other Assistance to Domestic Individuals. Complete if the organization answered "Yes" on Form 990, Part IV, line 22. Part III can be duplicated if additional space is needed.					
	(a) Type grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of Noncash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
1						
2						
3						
4						
5						
6						
7						

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Schedule J	Compensation Information		
	Name of organization	Employer identification number (EIN)	
	Clinch County Hospital Authority	58-6011853	
Part I	**Questions Regarding Compensation**		
			Yes/No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items		
	First-class or charter travel		
	Travel for companions		
	Tax indemnification and gross-up payments		
	Discretionary spending account		
	Housing allowance or residence for personal use		
	Payments for business use of personal residence		
	Health or social club dues or initiation fees		
	Personal services (such as maid, chauffeur, chef)		
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No,"	**1b**	
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked on line 1a?	**2**	
3	Indicate which, if any, of the following the organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.		
	Compensation committee		
	Independent compensation consultant		
	Form 990 of other organizations		
	Written employment contract	X	
	Compensation survey or study	X	
	Approval by the board or compensation committee	X	
4	During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization: If "Yes" to any of lines 4a–c, list the persons and provide the applicable amounts for each item in Part III.		
a	Receive a severance payment or change-of-control payment?	**4a**	No
b	Participate in or receive payment from a supplemental nonqualified retirement plan?	**4b**	No
c	Participate in or receive payment from an equity-based compensation arrangement?	**4c**	No
	Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5–9.		
5	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of: If "Yes" on line 5a or 5b, describe in Part III.		
a	The organization?	**5a**	No
b	Any related organization?	**5b**	No
6	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of: If "Yes" on line 6a or 6b, describe in Part III.		
a	The organization?	**6a**	No
b	Any related organization?	**6b**	No
7	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described on lines 5 and 6? If "Yes," describe in Part III	**7**	No
8	Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	**8**	No
9	If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	**9**	No
Part III	**Supplemental Information**		
	Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II in the space provided below. Also complete this part for any additional information.		

Schedule J **Compensation Information**

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Schedule J	**Compensation Information**
Part II	**Officers.** Use duplicate copies if additional space is needed.
	For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that aren't listed on Form 990, Part VII.
	Note: The sum of columns (B)(i)–(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual The sum of columns (B)(i)–(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual

	(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC and/or 1099-NEC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form
			(i) Base compensation	(II) Bonus & incentive compensation	(iii) Other reportable compensation				
1	Angela P. Handley	(i)							
	CEO	(ii)	164,594		2,077		5,645	$ 172,316.00	
2		(i)							
		(ii)							
3		(i)							
		(ii)							
4		(i)							
		(ii)						$ -	
5		(i)							
		(ii)						$ -	
6		(i)							
		(ii)						$ -	
7		(i)							
		(ii)						$ -	
8		(i)							
		(ii)						$ -	
9		(i)							
		(ii)						$ -	
10		(i)							
		(ii)						$ -	
11		(i)							
		(ii)						$ -	
12		(i)							
		(ii)						$ -	
13		(i)							
		(ii)						$ -	
14		(i)							
		(ii)						$ -	
15		(i)							
		(ii)						$ -	
16		(i)							
		(ii)						$ -	

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Schedule J	**Compensation Information**
Part II	**Directors & Trustees.** Use duplicate copies if additional space is needed.
	For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that aren't listed on Form 990, Part VII.
	Note: The sum of columns (B)(i)–(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual The sum of columns (B)(i)–(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual

	(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC and/or 1099-NEC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form
			(i) Base compensation	(II) Bonus & incentive compensation	(iii) Other reportable compensation				
1		(i)							
		(ii)						$ -	
2		(i)							
		(ii)						$ -	
3		(i)							
		(ii)						$ -	
4		(i)							
		(ii)						$ -	
5		(i)							
		(ii)						$ -	
6		(i)							
		(ii)						$ -	
7		(i)							
		(ii)						$ -	
8		(i)							
		(ii)						$ -	
9		(i)							
		(ii)						$ -	
10		(i)							
		(ii)						$ -	
11		(i)							
		(ii)						$ -	
12		(i)							
		(ii)						$ -	
13		(i)							
		(ii)						$ -	
14		(i)							
		(ii)						$ -	
15		(i)							
		(ii)						$ -	
16		(i)							
		(ii)						$ -	

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Schedule J	**Compensation Information**
Part II	**Key Employees.** Use duplicate copies if additional space is needed.
	For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that aren't listed on Form 990, Part VII.
	Note: The sum of columns (B)(i)–(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual The sum of columns (B)(i)–(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual

	(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC and/or 1099-NEC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form
			(i) Base compensation	(II) Bonus & incentive compensation	(iii) Other reportable compensation				
1		(i)							
		(ii)						$ -	
2		(i)							
		(ii)						$ -	
3		(i)							
		(ii)						$ -	
4		(i)							
		(ii)						$ -	
5		(i)							
		(ii)						$ -	
6		(i)							
		(ii)						$ -	
7		(i)							
		(ii)						$ -	
8		(i)							
		(ii)						$ -	
9		(i)							
		(ii)						$ -	
10		(i)							
		(ii)						$ -	
11		(i)							
		(ii)						$ -	
12		(i)							
		(ii)						$ -	
13		(i)							
		(ii)						$ -	
14		(i)							
		(ii)						$ -	
15		(i)							
		(ii)						$ -	
16		(i)							
		(ii)						$ -	
17		(i)							
		(ii)						$ -	
18		(i)							
		(ii)						$ -	
19		(i)							
		(ii)						$ -	
20		(i)							
		(ii)						$ -	

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Schedule J	**Compensation Information**
Part II	**Highest Compensated Employees.** Use duplicate copies if additional space is needed.
	For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that aren't listed on Form 990, Part VII.
	Note: The sum of columns (B)(i)–(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual The sum of columns (B)(i)–(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual

	(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC and/or 1099-NEC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form
			(i) Base compensation	(II) Bonus & incentive compensation	(iii) Other reportable compensation				
1	Igor Ancor	(i)							
	Physician/Medical Director	(ii)	321,614	75,000	4,077		7,536	$ 408,227.00	
2									
3									
4									
5		(i)							
		(ii)						$ -	
6		(i)							
		(ii)						$ -	
7		(i)							
		(ii)						$ -	
8		(i)							
		(ii)						$ -	
9		(i)							
		(ii)						$ -	
10		(i)							
		(ii)						$ -	
11		(i)							
		(ii)						$ -	
12		(i)							
		(ii)						$ -	
13		(i)							
		(ii)						$ -	
14		(i)							
		(ii)						$ -	
15		(i)							
		(ii)						$ -	
16		(i)							
		(ii)						$ -	

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Schedule R	**Related Organization and Unrelated Partnerships**					
	Name of organization				Employer identification number (EIN)	
	Clinch County Hospital Authority				58-6011853	
Part I	**Identification of Disregarded Entities.** Complete if the organization answered "Yes" on Form 990, Part IV, line 33.					
	(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)						
(2)						
(3)						
(4)						
(5)						
(6)						

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Schedule R Part II	**Related Organization and Unrelated Partnerships** **Identification of Related Tax-Exempt Organizations.** Complete if the organization answered "Yes" on Form 990, Part IV, line 34, because it hadone or more related tax-exempt organizations during the tax year.						
	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) exempt code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?
(1)	Clinch Memorial Foundation Inc 1050 Valdosta Hwy Homerville, GA 31634 EIN 83-0666651	Foundation	GA	501 c3	12B		No
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							

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Schedule R Part III	**Related Organization and Unrelated Partnerships** **Identification of Related Organizations Taxable as a Partnership.** Complete if the organization answered "Yes" on Form 990, Part IV, line 34, because it had one or more related organizations treated as a partnership during the tax year.										
	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512—514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?	(i) Code V—UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?	(k) Percentage ownership
(1)											
(2)											
(3)											
(4)											
(5)											
(6)											
(7)											

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Schedule R	**Related Organization and Unrelated Partnerships**								
Part IV	Identification of Related Organizations Taxable as a Corporation or Trust. Complete if the organization answered "Yes" on Form 990, Part IV,line 34, because it had one or more related organizations treated as a corporation or trust during the tax year.								
	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) percentage ownership	(i) Section 512(b)(13) controlled entity?
(1)									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									

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Schedule R	**Related Organization and Unrelated Partnerships**		
Part V	**Transactions With Related Organizations.** Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36		
	Note: Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.		**Yes/No**
1	During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II–IV?		
a	Receipt of (i) interest, (ii) annuities, (iii) royalties or (iv) rent from a controlled entity?	**1a**	
b	Gift, grant or capital contribution to related organizations?	**1b**	
c	Gift, grant or capital contribution from related organizations?	**1c**	
d	Loans or loan guarantees to or for related organizations?	**1d**	
e	Loans or loan guarantees by related organizations?	**1e**	
f	Dividends from related organizations?	**1f**	
g	Sale of assets to related organizations?	**1g**	
h	Purchase of assets from related organizations?	**1h**	
i	Exchange of assets?	**1i**	
j	Lease of facilities, equipment or other assets to related organizations?	**1j**	
k	Lease of facilities, equipment or other assets from related organizations?	**1k**	
l	Performance of services or membership or fundraising solicitations for related organizations?	**1l**	
m	Performance of services or membership or fundraising solicitations by related organizations?	**1m**	
n	Sharing of facilities, equipment, mailing lists or other assets?	**1n**	
o	Sharing of paid employees?	**1o**	
p	Reimbursement paid to related organizations for expenses?	**1p**	
q	Reimbursement paid by related organizations for expenses?	**1q**	
r	Other transfer of cash or property to related organizations?	**1r**	
s	Other transfer of cash or property from related organizations?	**1s**	

2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds

	(a) Name of related controlled organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
1				
2				
3				
4				
5				
6				

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Schedule R **Related Organization and Unrelated Partnerships**

Part VI **Unrelated Organizations Taxable as a Partnership.** Complete if the organization answered "Yes" on Form 990, Part IV, line 37

Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization. See instructions regarding exclusion for certain investment partnerships.

	(a) Name, address, and EIN of entity	(b) Primary Activity	(c) Legal Domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(e) Are all partners section 501c)(3) organizations?	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?	(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?	(k) Percentage ownership
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											
16											

Part VII **Supplemental Information** Provide additional information for responses to questions on Schedule R in the space provided below. See instructions.

Schedule R Related Organization and Unrelated Partnerships